

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12777

CERTIFICATE OF DEATH

Reg. Dist. No.

251

1. PLACE OF DEATH:

County.....

Dover, Anne Ar.

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

9 weeks

Hospital, Institution, or street address where death occurred: _____

How long in hospital or institution?.....

3. (a) FULL NAME

John Benedict Aughey

Sex

 M

5. Color or race

 W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife.....

Bertha F. Aughey

7. Birth date of deceased (mo., day, yr.)

Feb 9, 1860

6. (c) If alive, give age..... years

8. AGE: Years

88

Months

9

Days

37

If less than one day

hrs.

min.

9. Birthplace.....

Philadelphia

(Town, county, and state)

10. Usual occupation.....

Customs Inspector

11. Industry or business

MOTHER

FATHER

12. Name.....

John Muir Aughey

13. Birthplace

Philadelphia

14. Maiden name.....

Lambert

15. Birthplace

Lambert

16. Informant.....

Dorothy Wallace

Address

Porterfield, Md

17. Burial

Date thereof Dec 10 1948

(Burial, cremation, or removal. Which?)

(Month) (day) (year)

Cemetery or crematory

Haddonfield Baptist Cemetery

Location

Haddonfield, N.J.

18. Funeral director

Edward J. Lowe

Address

Milington, Md.

19. Dec 7 1948

Edgar L. Lane

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Pa

County.....

Phila.

City or town.....

Philadelphia

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

237 Hurst Ave

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Dec 10 1948 at 5 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dec 1 1948 to Dec 10 1948

and that I last saw him/her alive on Dec 5 1948

Immediate cause of death.....

Cardiac Dilatations

Due to..... Chronic Myocarditis

Due to..... Ocular Sarcoma

Other conditions..... Senility

(Include pregnancy within 3 months of death)

Major findings of operations.....

—

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

—

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

—

Means of injury.....

—

Injured at work?

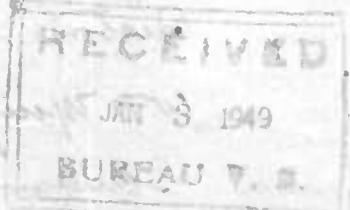
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23. SIGNATURE.....

John Wallace

M. D. or other

Address..... Portersville, Md. Date signed 12/10/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Reg. Dist. No. 2-52

CERTIFICATE OF DEATH

83a

1. PLACE OF DEATH:

County *Queen Anne's*City or town *Centreville*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *all his life*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

*Elijah Burton Green*4. Sex *Male* 5. Color at time of death *white* 6. (a) Single, married, widowed, or divorced *Widowed*6. (b) Name of husband or wife *Mary Quincy*7. Birth date of deceased (mo., day, yr.) *November 17 - 1868*8. AGE: Year *80* Month *0* Day *19* If less than one dayhrs. *0* min. *0*9. Birthplace *Centreville 2nd Maryland*

(Town, county, and state)

10. Usual occupation *Farmer*11. Industry or business *Elijah B. Green*12. Name of father *Elijah B. Green*13. Birthplace *Delaware*14. Maiden name *Mary*15. Birthplace *Do not know*16. Informant *Mrs Joseph R. Bayles*Address *Centreville Maryland*17. Burial *Buried* Date thereof *Dec 9-48*

(Burial, cremation, or removal, which?)

Cemetery or *Chesterville*Location *Centreville Maryland*18. Funeral director *Barton Ross*Address *Centreville Maryland*19. 12-9-48 *Elijah Armstrong*

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Queen Anne's*City or town *Centreville*
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war *None*

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec 7 - 1948*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Dec 3 - 1948*, to *Dec 7 - 1948*and that I last saw him alive on *Dec 7 - 1948*

Immediate cause of death

Cerebral hemorrhage

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

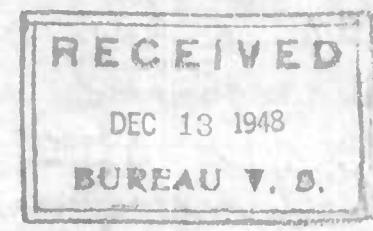
Injured at work?

23. SIGNATURE

W. Harvey Frost

M. D. or other

Address *Centreville Md* Date signed *12-8-48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12779

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH

County.....

City or town.....

*Queen Anne's
Lindensville*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *5 yr*

Hospital, institution, or street address where death occurred:

How long in hospital or Institution?

3. (a) FULL NAME

Nathan G. Johnson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Mab White Married

6. (b) Name of husband or wife

Bessie May

7. Birth date of deceased (mo. day, yr.)

6. (c) If alive, give age years

Aug 12, 1875

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

Maryland

10. Usual occupation

Retired Merchant

11. Industry or business

General Store

MOTHER FATHER

12. Name

John W. Johnson

13. Birthplace

Maryland

14. Maiden name

Mary E. Satterfield

15. Birthplace

Maryland

16. Informant

Mrs. Bessie M. Johnson

Address

Lindensville Md.

17. Burial

Date thereof *Dec 19, 1948*

(month) (day) (year)

(Burial, cremation, or removal. Where?)

Cemetery or crematory

Lindensville

Location

Lindensville Md.

18. Funeral director

Edward W. Flows

Addressee

*Wilmington Md.*19. *12/18*

1948

(Date rec'd by registrar)

Edgar L. Lane

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md. County Queen Anne's

City or town.....

Lindensville

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

more

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 16

1948 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

*Dec 1, 1948 to Dec 19, 1948*and that I last saw him alive on *Dec 15, 1948*

Immediate cause of death

Acute Pulmonary Embolus

DURATION

Due to

Acute Cardiac Deterioration

DURATION

Due to

Acute Myocarditis

DURATION

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Meane of injury

Injured at work?

23. SIGNATURE

C. M. McCalfe

M. D. or other

Lindensville Twp. Date signed 12/10/48

RECEIVED

JAN 3 1949

BUREAU F. B.

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12780

CERTIFICATE OF DEATH

Reg. Diet. No. 251

1. PLACE OF DEATH:

County

City or town

Queen Anne
Church Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Alice A. Mac Donald

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Fem. white

Widowed

6. (b) Name of husband or wife

John Mac Donald

deceased

7. Birth date of

deceased (mo., day, yr.)

March 28 - 1890

8. AGE:

Years Months Days It less than one day

78 8 29

hrs. min.

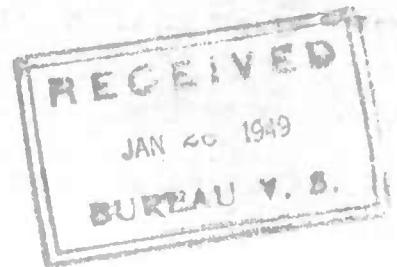
9. Birthplace

(Town, county, and state)

New Jersey

10. Usual occupation

Housewife



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 253

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County.....

City or town.....

Queen Anne
Chester

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Helen Caroline Koch

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

fem. White married

6. (b) Name of husband or wife

Arthur S. Koch

55

7. Birth date of deceased (mo., day, yr.)

Feb. 2 - 1893

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Baltimore Md

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business.....

Samuel Seayman

12. Name.....

Baltimore Md.

13. Birthplace.....

14. Maiden name.....

Margaret Kensis

15. Birthplace.....

Baltimore Md

16. Informant.....

Mr. Arthur Koch

Address.....

Chester Md

17. Burial.....

Burial

Date thereof..... Dec. 31-1948
(Burial, cremation, or removal. Which?)
(month) (day) (year)

Cemetery or crematory.....

Mt. Olivet

Location.....

Baltimore Md

18. Funeral director.....

Edgar L. Lane

Address.....

Church Hill Md.

19. When, 31

1948 Elizabeth Foster

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Queen Anne

City or town.....

Chester

Street No.....

(If outside city or town limits, write RURAL and give nearest town)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 28. 1948 at 2 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 27 1948 Dec. 28 1948

and that I last saw her alive on Dec. 28 1948

Immediate cause of death.....

Cerebral hemorrhage

Due to.....

Arteriosclerosis

Neurosis - Sclerosis

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

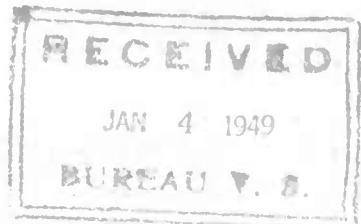
Injured at home, farm, industry, public place (where?)

Meane of injury..... Injured at work?

23. SIGNATURE.....

Theodor Sattelmaier M.D. or other

Addressee..... Stevensville Date signed..... 12/29/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Sattelmaier
12782

CERTIFICATE OF DEATH

Reg. Dist. No. 253

1. PLACE OF DEATH:

County

Kent Queen Anne

City or town

Chester

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

all of life

Hospital, institution, or street address where death occurred

How long in hospital or institution?

3. (a) FULL NAME

Jacob B. Tolson

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

white

Married

6.(b) Name of husband or wife

Bessie M. Tolson

7. Birth date of deceased (mo., day, yr.)

May 21, 1879

8. AGE:

Years Months Days If less than one day

69

7

6

hrs.

min.

9. Birthplace

Chester Queen Anne Md

(Town, county, and state)

10. Usual occupation

Oyster packer

11. Industry or business

James H. Tolson

12. Name

Kent Island Md

13. Birthplace

Victoria Lewis

14. Maiden name

Kent Island Md

15. Birthplace

Mrs. Bessie M. Tolson

16. Informant

Address

Chester - Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Dec. 30, 1948

(month) (day) (year)

Cemetery or crematory

Stevensville

Location

Stevensville Md

18. Funeral director

Maurice E. Dawson Fox

Address

Easton Maryland

19. Date rec'd by registrar

Dec. 30 1948 Elizabeth Hayes

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

City or town

Chester

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

45
Dec. 27 1948 at 7 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 26 1948 to Dec. 27 1948.

and that I last saw h. m. alive on Dec. 27 1948.

Immediate cause of death

Coronary thrombosis

Due to

Arterio sclerosis

Due to

diabetes mellitus

Other conditions

multiple sclerosis

15 years

5 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

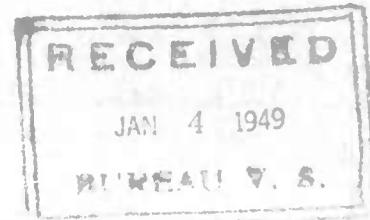
23. SIGNATURE

Theodor Sattelmaier, M.D.

M. D. or other

Address Stevensville

Date signed 12-28-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12783

CERTIFICATE OF DEATH

Reg. Dist. No.

252

1. PLACE OF DEATH: Queen Anne

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 35 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William Walton

4. Sex

Male

5. Color of race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife.....

Dont know

7. Birth date of deceased (mo. day. yr.)

1884

6.(c) If alive, give age..... years

8. AGE: Years

64

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

Dont know

(Town, county, and state)

10. Usual occupation.....

Laborer

11. Industry or business.....

Dont know

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Mary Barnes (niece)

Address

Centerville Md

17. Burial

(Burial, cremation, or removal. Which)

Date thereof Dec 24-48
(month) (day) (year)

Cemetery or crematory.....

Cemetery (Private)Location Mr. Centerville Md

18. Funeral director.....

Sevis C. Henry

Address

Centerville Md19. 12-22-48 (Date rec'd by registrar)

(Date received by registrar)

Elie Armelous

Registrar

Address Centerville Md Date signed 12/21/48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD

County.....

Queen Anne

City or town.....

Centerville

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 - 1948 at 3 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1948 to Dec 21 1948and that I last saw h. alive on Dec 10 1948

Immediate cause of death.....

Mitral Regurgitation

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE

W. D. Henry Fisher

M. D. or other

Address Centerville Md Date signed 12/21/48

